DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085009	A. BUILDING _____ B. WING _____	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST MANOR HOUSE	1001 MIDDLEFORD ROAD SEAFORD, DE 19973

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F 000	INITIAL COMMENTS An annual survey was conducted at the facility from July 25, 2011 through August 1, 2011. The deficiencies contained in this survey report are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The census on the first day of the survey was fifty (50) and the Stage II sample included twenty-five (25) residents.	F 000	**Disclaimer Statement** Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction of prepared and/or executed solely because it is required by the provision of federal and state law. This Plan represents the facility's credible allegation of compliance as of 9/3/2011	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by : Based on clinical record review, interview, and observation it was determined that the facility failed to provide care in a manner that enhanced resident dignity for one (R35) out of 25 sampled residents. Findings include: In March 2011, R35 was diagnosed with a Staph infection in her eyes then. Then on 5/23/11, R35 was diagnosed with MRSA (Methicillin-Resistant Staphylococcus Aureus) of both eyes. Review of R35's nurses note revealed "Infection in both eyes 3/31/11. Ok to eat in room until eye issue of staph is resolved." Review of R35's physician orders revealed on 5/23/11 the physician wrote an order for "Contact	F 241	F 241 1. Infection Control RN interviewed and made aware of deficient practice and correct order for Contact Precautions was obtained. Dietary restrictions were removed and staff education began immediately. 7/26/2011 2. All nurses will have Mandatory Education on the facility Infection Control Policies and Procedures and staff will demonstrate a working knowledge and understanding of subject by post in-service test. Resident Rights will 8/26/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan K Hankinson | TITLE: Executive Director | (X6) DATE: 8/25/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Isolation." Review of the July 2011 physician order sheet for R35 revealed a physician order that stated "...bilateral eye infection contact precautions only." Review of the facility's "Communication-Nursing to Dietary Manager and/or Dietitian" form for R35 revealed on 5/23/11 staff sent a message to dining service stating "Isolation Tray-All disposables until further notice." On 7/28/11 at approximately 1 PM E9 (Certified Nursing Assistant/CNA) was observed collecting lunch trays from residents' rooms. When asked about a lunch tray for R35, E9 stated that R35 received all her meals on disposable plastic or paper products in her room because she had MRSA of her eyes. E9 continued to state that R 35's meal trays are disposed of in the trash can in her room. At approximately 9AM on 7/29/11 E10 (CNA) was observed feeding R35 in her room wearing gloves . Upon interview, E10 stated that R35 was fed in her room, using plastic utensils and disposable plates and cups because she was on contact isolation for MRSA in her eyes even though she was fed by the staff. On 8/1/11 at 10:15 AM interview with R35 revealed she was banned from the dining room and told she had to eat in her room due to the infection in her eyes. R35 stated she will be glad when the ban was over and she could go to the dining room if she wanted to. On 8/1/11 at 10:25 AM interview with E3 (RN/ Infection control) confirmed that R35 was made	F 241	also be reviewed during in-service with the focus on Dignity of the Resident. 3. Any new cases requiring isolation will be audited by Infection Control RN on admission to ensure compliance with our policy and procedures. All staff, including Certified Nursing Assistants will complete annual Silver Chair education on Resident Rights and Infection Control. Monthly audit of current residents on isolation will be completed by Infection Control RN to ensure ongoing compliance. 4. Finding will be reported monthly at QI meetings followed by Quarterly meetings for one year.	8/26/2011 9/3/2011

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F 241	Continued From page 2 to eat in her room on disposable products, and banned from the dining room due to the infections in her eyes. E3 continued to state that R35 should not have been eating on disposable products and should not have been banned from the dining room. The staff needed to wear gloves when in contact with drainage from R35's eyes. E3 continued to state that R35 was on contact isolation and everyone should use universal precautions. E3 also stated that the Infection control program was turned over to her 2 weeks ago; however, she will take care of the problems and initiate education to the staff.	F 241		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F279 1. MDS Coordinator is responsible for the ensuring that all care plans are being updated and individualized for all residents. R16, R50, and R35's care plans have been updated. R50 was discharged prior to updating care plan. 8/12/2011 2. A review of all residents with contractures, splints, psychoactive medications and impaired skin integrity will be completed by September 2, 2011. All nurses will attend an Individualizing Care Plans in-service by September 2, 2011. 9/2/2011 3. MDS Coordinator will review all care plans during individual 9/2/2011	

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F 279	Continued From page 3 This REQUIREMENT is not met as evidenced by : Based on record review and interview it was determined that for four (R16, R71, R50, and R35) out of 25 sampled residents the facility failed to develop a care plan for an identified need. Findings include: 1. Cross refer F318. R16 had diagnoses which included contractures of the joints of her hands and posture abnormalities. R16's record contained a therapy discharge summary signed by the occupational therapist on 1/3/11 that included the wearing of palm protectors on both hands. A rehabilitation department/nursing communication form was also on the record with these recommendations dated 1/3/11. Observation of the resident during the day shift hours from 7/25 through 7/29/11 noted the resident not to be wearing a palm protector. Review of the care plan, restorative book and a CNA (Certified Nursing Assistant) information sheet revealed that there was no information indicating the use of a palm protector. An interview on 7/29/11 at 12:51 PM with E4 (Registered Nurse Assessment Coordinator) revealed there was no care plan for contractures and no documentation of the use of palm protector splints. An interview on 7/29/11 at 1:05 PM with E2 (	F 279	quarterly Care Conference meetings to ensure that all of the individual's needs are addressed in their care plan. MDS Coordinator will do weekly audits for 3 months and quarterly thereafter for one year to ensure compliance. 4.Findings will be reported monthly at QI meeting for the next 3 months followed by quarterly for one year.	9/3/2011

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F 279	Continued From page 4 Interim Director of Nursing) confirmed that there was no care plan for the contractures and the use of palm protector splints. 2. Cross refer F314. Review of the admission Minimum Data Set (MDS) assessment dated 4/25/11 revealed that R 50 had three, Stage I pressure ulcers (PU) and was assessed at risk of developing a PU. Review of R50's care plans revealed an "Interim Plan of Care" implemented on 4/18/11 for " Potential/Actual skin breakdown due to impaired mobility", however, there was not an actual care plan for the three, Stage I PU as noted on the above MDS assessment. Nurse's Note dated 4/30/11 timed 2 PM documented "pressure area (1.3 X 0.8) found by CNA (certified nursing assistant) on right heel. 2n 1 (barrier cream) applied and heels were floated." Subsequent to this new PU, an order was obtained on 4/30/11 to "Apply 2n1 to bilateral heels every shift, float heels (elevate heel to relieve pressure to the heels), and measure and record every 5 days." Although R50 had acquired another new PU of the right heel, the facility failed to implement an actual care plan to include the above interventions. An interview with E4 (MDS Coordinator) on 7/29/ 11 at approximately 11:30 AM confirmed that there were no care plans for the three new PUs identified on 4/24/11 or the right heel PU identified on 4/30/11.	F 279		

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F 279	Continued From page 5 3. R71 was admitted to the facility on 5/29/11 with diagnoses including non-syncopal fall, weakness, glaucoma, depression, dementia, osteoarthritis, mild anxiety, and advanced age. Review of the July 2011 Physician's Order Record documented that R71 was ordered Ativan (medication to treat anxiety) 0.5 mg. (milligram) by mouth twice a day for anxiety. Record review lacked evidence of a comprehensive care plan for the use of a psychoactive medication including it's indication for use, monitoring needs, side effects and non-pharmacological interventions personalized to meet the resident needs. Interview with E2 on 7/29/11 at 9 AM revealed that there was no care plan for anxiety. 4. R35 was diagnosed with rheumatoid arthritis. Review of a physical therapy evaluation completed for R35 dated 3/4/11 revealed the staff were required to do upper extremity range of motion except for R35's hand and fingers due to " ulnarly deviated" (sic). Review of R35's physician orders revealed an order dated 6/23/11 to "apply hard splints with finger separations to both hands after evening bath. Resident to wear bilateral hand splints all night." Review of R35's care plans on 7/28/11 at 1:14PM with E5 (Licensed Practical Nurse) revealed that the facility failed to develop a care plan concerning R35's contractures, order for hard	F 279		

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F 279	Continued From page 6 hand splints and physical therapy's instructions for R35's range of motion including the exception of her hands and fingers. The care plans for R35 were also reviewed with E 4 (Registered Nurse Assessment Coordinator) on 7/28/11 at 1:30 PM who immediately developed a care plan addressing R35's contractures, physician orders and therapy's evaluation and instructions for range of motion.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by : Based on record review and interview it was determined that the facility failed to ensure that qualified persons provided the care in accordance with the written plan of care for two (R50 and R32) out of 25 sampled residents. When R50 acquired three new pressure ulcers on 4/24/11 and one new pressure ulcer (PU) on 4/30/11, the facility failed to accurately and comprehensively assess the pressure ulcers including the stage of the ulcer. The facility failed to ensure that R32, who was assessed at high nutritional risk was provided the nutritional supplement as ordered. Findings include: 1. Cross refer F314. R50 was readmitted to the facility on 4/18/11. On 4/24/11, record review revealed the presence of three new pressure ulcers as documented on the	F 282	F282 1. Through record review and interview with surveyors, Interim Director of Nursing identified that staff did not have an understanding of and were not following current policy and procedures in regards to caring for residents with Non-impaired Skin Integrity and Impaired Skin Integrity. Through record review, consultation with Registered Dietician, resident's son and the physician, Interim Director of Nursing identified that the Ensure that was ordered for R32 should have been previously discontinued. Resident's weight was stable and she voiced to staff and her son that she did not want to drink the Ensure. The order	7/26/2011

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F 282	Continued From page 7 "Weekly Wound Assessment" forms: - Two PUs noted of left buttock with appearance of red with size of wound 0.5 cm (centimeter) and 1 cm. respectively. However, the facility failed to include the stage of the PU. The next reassessment completed approximately three weeks later on 5/13/11 indicated that both of the PUs had healed. - One PU of the coccyx was documented as having a red appearance with 0.5 cm. the size of the wound. However, the facility failed to include the stage of the PU. No further reassessment was documented on this form. In addition, on 4/30/11, a new PU of the right heel was documented on the "Weekly Wound Assessment" with necrotic appearance measuring 1.3 cm. in length and .8 cm. in width, however, the documentation failed to include the stage of the PU. The reassessments were documented on 5/13/11, 5/20/11, and 5/25/11. In addition, the documentation noted that the wound healed on 6/19/11. Record review lacked evidence of a weekly assessment. An interview with E2 (Interim DON) on 7/29/11 at approximately 11:45 AM revealed that during the current survey, it was identified that the licensed staff nurses were under the incorrect understanding that when a PU was identified, that they do not need to stage the PU since the staging was delegated to a previously contracted wound specialist. E2 relayed that the facility was no longer utilizing the wound specialist and that the licensed nurses were expected to accurately and comprehensively assess the wound including the stage of the wound minimally on a weekly basis per the facility's policy.	F 282	was immediately discontinued. Education began immediately to all nurses clarifying these issues. 2. Education will be given to all nurses on how to comprehensively assess pressure ulcers including the staging of ulcers; how to accurately complete a Weekly Wound Assessment Form; how and when to reassess a resident for impaired skin integrity issues and how to accurately document when a wound is healed. Facility policy and procedures on Non-impaired Skin Integrity and Impaired Skin Integrity will be reviewed with the staff. This education will be completed by September 2, 2011. Education will be given to all nurses regarding the accurate entry of all supplements in to the Millennium Pharmacy system and Care tracker for the certified nursing assistant documentation. 3. RN member of Wound Care Team will present and provide weekly reports at the SWIF meeting. RN Supervisor will do weekly audits of all Weekly Wound Care forms for 3 months and quarterly thereafter for	8/26/2011 9/3/2011

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F 282	Continued From page 8 A subsequent interview with E1 (Administrator) on 8/2/11 at approximately 1 PM revealed that it was her understanding that the facility was following both of the policies and procedures (" Non-Impaired Skin Integrity" and "Skin Integrity-Impaired") and that the wound care team was functioning. 2. Cross refer F325. Review of R32's July 2011 physician orders included Ensure (nutritional supplement) once a day and ice cream at bedtime and cheese and crackers at PM. The physician order sheet also documented under plans of care " 9 AM Ensure drink daily please check med room family to provide patient likes drink room temp." Review of R32's care plan revealed there was a care plan for her high nutritional risk as evidence by BMI (Body Mass Index) under 21 with interventions that included Ensure daily and that she enjoyed the Ensure at room temperature. Review of R32's clinical record revealed there was no documentation indicating R32 was receiving Ensure as ordered by the physician and care planned. An observation made on 7/28/11 at 9:20 AM revealed R32 did not have Ensure in her room or on her tray. On 7/28/11 at 9:25 AM interview with E5 (Licensed Practical Nurse) revealed that she did not know that R32 was to receive Ensure daily.	F 282	one year to ensure accuracy and completion. Registered Dietitian or her designee will do a monthly audit of all supplements ordered for 90 days to ensure that they are being given and recorded. In our weekly SWIF meeting, all supplements will be discussed and if supplement is not deemed necessary, it will be discontinued from the chart immediately per MD order. 4. Findings will be reported monthly at QI meeting for the next 3 months followed by quarterly meetings for one year. Findings will be reported monthly x's 3 at the QI meeting and a report will be given at a quarterly meeting once if the problem has been resolved. If there is evidence that the problem still exists, the audit will be extended for another quarter.	9/3/2011

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F 282	Continued From page 9 E5 continued to state that when a resident is ordered Ensure the CNA (Certified Nursing Assistant) give it to them. On 7/28/11 at 9:45 AM review of the CNA's " Patient Care Plan" for R32 with E4 (Registered Nurse Assessment Coordinator) revealed a lack of documentation communicating to the CNA's that R32 was to receive Ensure daily. Review of R32's order and care plan for Ensure with E8 (CNA) on 7/28/11 at 10:30 AM revealed the CNAs were not aware of the Ensure order because it was not documented on R32's Patient Care Plan and it was not put in their computer as a task to be done.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/ HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by : Based on record review, interviews, and review of facility's policies, it was determined that the facility failed to provide the necessary treatment and services to one (R50) out of 25 sampled residents who had pressure ulcers (PU). The facility failed to accurately assess R50's risk for	F 314	F314 1. Through record review and interview with surveyors, Interim Director of Nursing identified that staff did not have an understanding of and were not following current policy and procedures in regards to caring for residents with Non-impaired Skin Integrity and Impaired Skin Integrity. Education began immediately to all nurses clarifying these issues.	7/26/2011

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F 314	Continued From page 10 the development of a new PU when R50 experienced a change in condition following a left hip arthroplasty (hip replacement surgery). This failure resulted in the lack of interventions being implemented and R50 acquired two new PU of the left buttocks and one new PU of the coccyx area on 4/24/11. In addition, on 4/30/11, R50 acquired a new, unstageable left heel PU. Lastly, the facility failed to accurately and comprehensively assess R50's new PUs. Findings include: R50 was originally admitted to the facility on 4/8/11 following a fall in the assisted living facility which resulted in a left hip fracture. In addition, R 50 had diagnoses including severe advanced dementia, coronary artery disease, hypertension, and gastroesophageal reflux disease. On 4/14/11, R50 was admitted to the hospital for a left hip arthroplasty and on 4/18/11, R50 was readmitted to the facility. Review of the admission Minimum Data Set (MDS) assessment dated 4/25/11 revealed that the resident was severely impaired for daily decision making, required extensive assistance of two persons for bed mobility/transfer and was incontinent. In addition, R50 had three, stage I PUs and was assessed at risk for developing a PU. R50's Physician Order Record dated 4/18/11 noted the following treatment orders: - abductor wedge - hip precaution The "Interim Plan of Care" implemented on 4/18/11 for "Potential/Actual skin breakdown due to	F 314	2. Education will be given to all nurses on how to comprehensively assess pressure ulcers including the staging of ulcers; how to accurately complete a Weekly Wound Assessment form; how and when to reassess a resident for impaired skin integrity issues and how to accurately document when a wound is healed. Facility policy and procedures on Non-impaired Skin Integrity and Impaired Skin Integrity will be reviewed with the staff. This education will be completed by September 2, 2011. The Wound Care Team will make rounds weekly to ensure that all strategies which reduce the development and progression of pressure ulcers are in place and that all assessments of the wounds are accurate. 3. RN member of Wound Care Team will present and provide weekly reports at the SWIF meeting. RN supervisor will do weekly audits of all Weekly Wound Care forms for 3 months and quarterly thereafter for one year to ensure accuracy and completion.	8/26/2011 9/2/2011

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F 314	Continued From page 11 impaired mobility noted the following approaches: - turn and reposition every 2 hours - wash after every incontinence and apply barrier - keep clean and dry Review of the "Resident Status Information", a nursing assessment document dated 4/18/11 indicated that R50 had a "pink" discoloration of the sacral area. Interview with E15 (staff nurse who completed this document) on 7/28/11 at approximately 2:30 PM revealed that she recalled that the area was blanchable, thus, did not assess this as a PU. In addition, E15 relayed that the licensed staff nurses currently are not staging any PU. Review of the facility's policy titled "Non-Impaired Skin Integrity" indicated that the Braden Scale for predicting pressure sore risk will be completed by the licensed nurse in order to identify residents at risk of developing skin integrity upon admission and readmission. In addition, the policy indicated that "the wound care team will continually evaluate existing strategies to reduce the development and progression of pressure ulcers and monitor the incidence and prevalance of pressure ulcers." On 4/8/11, Braden Scale was completed and R50 was assessed as "low risk" for the development of PU. Although R50 was readmitted to the facility on 4/18/11 and had a change in condition following the left hip arthroplasty, record review lacked evidence of a Braden Scale to reassess R 50's risk of developing a new PU, therefore, failing to implement measures to prevent development of a new PU.	F 314	4.Findings will be reported monthly at QI meeting for the next 3 months followed by quarterly meetings for one year.	9/2/2011

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	085009	A. BUILDING _____ B. WING _____	08/01/2011

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F 314	Continued From page 12 An interview with E2 (Interim Director of Nursing/ DON) on 7/29/11 at approximately 11:40 AM confirmed that the facility failed to complete the Braden Scale upon R50's readmission on 4/18/11 . Nurse's Note (N.N.) dated 4/24/11 timed 12:30 PM documented "three reddened small areas observed on coccyx and left buttocks." and this was noted in the "...skin integrity book." On 4/24/11, three "Weekly Wound Assessment" forms were initiated documenting the three new PU sites: - Two PUs noted of left buttock with appearance of "red" with size of wound 0.5 cm. (centimeter) and 1 cm. respectively, however, failed to include the stage of the PUs. The next reassessment completed approximately three weeks later on 5/ 13/11 indicated that both of the PUs had healed. - One PU of the coccyx documented as having a "red' appearance with the 0.5 cm. size of wound, however, failed to include the stage of the PU. No further reassessment was documented on this form including when the PU healed. Review of the facility's policy titled "Skin Integrity-Impaired" indicated the following procedures are to be initiated by the licensed nurse upon identification of impaired skin integrity, regardless of severity or degree: a. Initial assessment of the wound using the " Initial Wound Assessment" form. d. Notification of the wound care team. h. Weekly wound assessment completion and evaluation of treatment interventions using the " Weekly Wound Assessment" form. Although R50 had three new PUs, the facility	F 314		

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F 314	Continued From page 13 failed to have a system which ensured accurate and comprehensive assessment of the PUs on a weekly basis. In addition, record review lacked evidence of an actual skin impairment care plan. An additional care plan for "potential for impaired skin integrity r/t (related to) impaired mobility and frequent incontinence of bowel and bladder implemented on 4/28/11 included goals that the skin will remain free of breakdown and that reddened areas will be promptly identified and tx (treatment) initiated. Approaches included: - Incontinence care after each episode - Low Air loss mattress - Apply barrier cream after each incontinence episode Subsequent N.N. dated 4/30/11 timed 2 PM documented "pressure area (1.3 X 0.8) found by CNA (certified nursing assistant) on right heel. 2n 1 (barrier cream) applied and heels were floated." Subsequent to this new PU, an order was obtained on 4/30/11 to "Apply 2n1 to bilateral heels every shift, float heels (elevate heel to relieve pressure to the heels), and measure and record every 5 days." On 4/30/11, a new PU of the right heel was documented on the "Weekly Wound Assessment " with "necrotic" (dead tissue) appearance measuring 1.3 cm. length and .8 cm. in width, however, the documentation failed to include the stage of the PU. An interview with E17 (staff Licensed Practical Nurse who assessed the new PU) on 8/2/11 at approximately 3 PM revealed that the "area was dark in color as if the area was laying on a surface too long." Reassessments were documented on 5/13/11, 5/	F 314		

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F 314	Continued From page 14 20/11, and 5/25/11 which continued to indicate the presence of "necrotic" tissue and without stage of the PU. The document noted that the PU healed on 6/19/11, however, the facility failed to follow the physician's order to measure and record every 5 days. Record review lacked evidence of an actual care plan for the new unstageable PU of right heel. An interview with E4 (MDS Coordinator) on 7/29/11 at approximately 11:30 AM revealed that due to the organizational changes, there has not been a wound care team consistently in place. E4 relayed that in the past, E4 and the facility's Nurse Practitioner (E16) would observe the wounds, however, this was not the current system. Lastly, E4 confirmed that there was not an actual skin breakdown care plan for the three new PU identified on 4/24/11 or the right heel PU identified on 4/30/11. An interview with E2 on 7/29/11 at approximately 11:45 AM revealed that during the current survey, it was identified that the licensed staff nurses were under the incorrect understanding that when a PU is identified, that they do not need to stage the PU since the staging was delegated to a previously contracted wound specialist. E2 relayed that the facility is no longer utilizing the wound specialist and that the licensed nurses are expected to accurately and comprehensively assess the wound including the stage of the wound. A subsequent interview with E1 (Administrator) on 8/2/11 at approximately 1 PM revealed that it was her understanding that the facility was following both of the above policies and	F 314		

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F 314	Continued From page 15 procedures ("Non-Impaired Skin Integrity" and " Skin Integrity-Impaired") and that the wound care team was functioning.	F 314	F318 1. Through record review and interview with surveyors, Interim Director of Nursing identified that splints used for the reduction of contractures were not being used and properly documented. An assessment of all residents using splints was immediately completed and a list compiled. Restorative Aid placed all splints in the Restorative Nursing Book and entered all splints on the CNA (certified nursing assistant) data book. All care plans have been updated to include splints and contractures.	7/26/2011
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by : Based on observation, record review, and interview it was determined that for one (R16) out of 25 sampled residents, the facility failed to ensure a splint device was used for a resident with a contracture. Findings include: R16 had diagnoses which included contractures of the joints in the hand and abnormal posture. R16's record contained a therapy discharge summary signed by the occupational therapist on 1/3/11 that included the wearing of palm protectors in hands. The summary noted that the resident takes them off multiple times a day. Resident was also very resistive to ROM (range of motion) to both hands. The recommendation was that R16 was to have ROM to hands and the use of palm protectors applied to both hands. A rehabilitation department/nursing communication form was also on the record with these recommendations dated 1/3/11.	F 318	2. Education will be given to all nurses, certified nursing assistants and the restorative aids concerning the proper use of splints and documentation. 3. Restorative Aid will do monthly audit of the presence of splints, proper use of splint and the appropriate documentation. Findings will be presented monthly in the Restorative Care meeting. This audit will be ongoing. 4. Findings will be reported monthly at QI meeting for the next 3 months	8/26/2011 9/3/2011 9/3/2011

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F 318	Continued From page 16 Observations of the resident during the day shift hours from 7/25 through 7/29/11 noted the resident to not be wearing a palm protector. Review of the care plan, restorative book and a CNA (Certified Nursing Assistant) care plan information sheet revealed that there was no information indicating the use of a palm protector. An interview on 7/28/11 at 2:55 PM with E12 (CNA) revealed that the resident had a palm protector in her room till about a month ago and she does not know what happened to it. E12 stated she tried to get her to keep her left hand open when able but that the resident did not like her right hand fussed with. An interview on 7/29/11 at 12:34 PM with E11 (staff nurse) revealed she had never seen splints in use for this resident. E11 checked the electronic record system and stated splints or palm protectors were not listed on the treatment record. An interview on 7/29/11 at 12:51 PM with E4 (staff nurse) revealed that she was unable to find any documentation of the use of splints in the former electronic charting system. E4 further stated that the new computer charting system cannot chart splints and the documentation should be in the CNA book. There was no documentation of the splints in the CNA books. An interview on 7/29/11 at 1:05 PM with E2 (Interim Director of Nursing) revealed no further evidence of the use of the splint. A follow-up interview at 1:23 PM with E2 revealed that the	F 318	followed by quarterly meetings for one year.	

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F 318	Continued From page 17 splint had been lost for an undetermined amount of time and that no documentation was being done on the use of the splint since it was initiated in January.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by : Based on clinical record review, observation and interview it was determined that the facility failed to ensure one (R32) out of 25 sampled residents received her therapeutic supplements as ordered by the physician. Findings include: R32 was originally admitted to the facility in August 2009. Review of R32's medical record revealed she had diagnoses that included degenerative disc disease, dementia with anxiety, depression, electrolyte abnormality, hypertension, hypothyroidism, irritable bowel syndrome, osteoporosis, and renal failure. Review of R32's 7/8/11 Minimum Data Set (MDS) assessment revealed R32 required extensive assistance with one person to assist with eating	F 325	F325 1. Through record review, consultation with Registered Dietician, resident's son and the physician, Interim Director of Nursing identified that the Ensure that was ordered for R32 should have previously discontinued. Resident's weight was stable and she voiced to staff and her son that she did not want to drink ensure. The order was immediately discontinued per MD order. 2. Education will be given to all nurses regarding the accurate entry of all supplements into the Millennium Pharmacy system and Care tracker.	7/26/2011 8/26/2011

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F 325	Continued From page 18 and with her activities of daily living. R32 was also assessed for impairment for range of motion on both upper extremities. Review of R32's weight data from 1/2011 through 7/2011 revealed she had a BMI (Body Mass Index) of 18 and her weight fluctuated between 103-106 pounds. Review of R32's July 2011 physician orders included orders for multivitamins, Remeron, calcium, Ensure once a day and ice cream at bedtime and cheese and crackers at PM. The physician order sheet also documented under plans of care "9 AM Ensure drink daily please check med room family to provide patient likes drink room temp." Review of R32's care plans revealed a care plan for her high nutritional risk as evidenced by BMI under 21 with interventions that included regular lactose milk diet, Ensure daily, ice cream twice a day, honor food preferences within diet regimen and that she enjoyed ensure at room temp. Review of R32's clinical record revealed there was no documentation indicating R32 was receiving Ensure as ordered by the physician and included in the care plan. Review of R32's weight and BMI with E7 (Registered Dietician) on 7/27/11 at approximately 2:10 PM revealed R32's weight had been around 100-106 pounds most of her life. When R32 was admitted in August 2009, her BMI was 18. E7 continued to state that she monitors R32's weight and R32 has a physician order for Ensure daily as a supplement. Her family brings in the Ensure	F 325	3. Registered Dietitian or her designee will do a monthly audit of all supplements ordered for 90 days to ensure that they are being given and recorded. In our weekly SWIF meeting, all supplements will be discussed and if supplement is not deemed necessary, it will be discontinued per MD order. 4. Findings will be reported monthly x's 3 at the QI meeting and a report will be given at a quarterly meeting once if the problem has been resolved. If there is evidence that problem still exist, the audit will be extended for another quarter	9/3/2011 9/3/2011

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F 325	Continued From page 19 and R32 likes to drink it at room temperature. An observation made on 7/28/11 at 9:20 AM revealed R32 did not have Ensure in her room or on her tray. On 7/28/11 at 9:25 AM interview with E5 (Licensed Practical Nurse) revealed that she did not know that R32 was to receive Ensure daily. E5 continued to state that R32's family does not bring Ensure in for R32. A search of R32's room with E5 revealed there was no Ensure in her room. E5 continued to state that when a resident is ordered Ensure the CNAs give it to them. On 7/28/11 at 9:45 AM a search of the med room with E4 (Registered Nurse Assessment Coordinator) revealed there was no Ensure in the medication room for R32. Review of the R32's clinical record lacked documentation that the family was notified of a need for Ensure for R32. Review of the CNA's "Patient Care Plan" for R32 with (E4) revealed a lack of documentation communicating to the CNA's that R32 was to receive Ensure daily.	F 325		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/ SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by	F 371	F371 1. Through observation it was noted that waste water contaminated a clean area. Education was given to staff to put dirty dishes in the drain and spray water down on to dishes and not spray dirty dishes on the stainless steel counter.	8/19/2011

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F 371	Continued From page 20 : Based on observations and interview in the dietary area, it was determined that facility failed to ensure that food was prepared and served under sanitary conditions. Findings include: 1. During the initial tour of the kitchen, on 7/25/11 at 11:40 AM, it was noted that waste water from the spray hose used to rinse dirty dishes and ware was splashing up to fourteen feet away from the work area. At this distance, clean ready-to-use cups, glasses and bowls, the food service tray line, and the ice machine were all within the potential contamination zone. This observation was repeated on 07/29/11 at 12:25 while touring with E13 (Food Service Director). 2. On 7/29/11 at 12:25 PM while touring with E13 , the internal temperature readings of the dish machine were 154.8°F, 155.9°F, and 153°F. This was below the 160°F required for proper sanitization. Interview with E13 on 8/01/11 indicated that the temperature of the water entering the hot water booster for the machine had been increased immediately to allow it attain the proper temperature.	F 371	2.A cover/shield was purchased and will be installed by 8/19/2011 to prevent waste water from reflecting off stainless steel counters. 3.Opening and closing managers will be responsible for checking that the Job Flows duties are done on a daily basis. A daily audit will be completed by managers for 90 days and finding will be taken to the monthly QI meetings. 4. Food Service Director or designee will report findings at the quarterly QI meeting. 1.Through observation it was noted that water temperatures were below the required 180 degree temperature for sanitation. Maintenance increased the water temperature that comes into the booster and the temperature increased immediately. 2.Temperature gauges and booster will be evaluated for accuracy and replaced if needed by 8/19/2011 3.The Dish staff is responsible for checking temperatures three times a day. Ongoing temperature	9/3/2011 9/3/2011 8/2/2011 8/19/2011 8/19/2011
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/ STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 431	Continued From page 21 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by : Based on observation it was determined that the facility failed to ensure medications were properly stored and labeled. Findings include: Observation of the Station 1 and Station 2 medication rooms and medication carts on 7/29/ 11 at 2:30 PM revealed the following; 1. Acetaminophen 325 mg. (milligram) 13 tablets expired 7/18/11 in back up stock. 2. Loratadine 7 tablets expired 7/14/11 in back up	F 431	logs are kept and reviewed by Food Services Director monthly. 4. Monthly audits are completed by Food Service Director and the findings are reported quarterly in QI meeting. F431 1. Expired medications and not dated open bottles were found during survey. All medications were destroyed immediately and a thorough audit of all other medications was completed to ensure that there weren't any other expired medications in the carts and medication room. 2. Education will be given to all nurses regarding the proper disposition of all expired medications and the requirement to date all open bottles and tubes of medication. Education will be given on the length of time certain medications can be opened before they must be destroyed. The education will be completed by September 2, 2011. 3. Weekly audits will be completed by the nursing staff on a rotating basis for three months. Findings	9/3/2011 7/26/2011 8/26/2011 9/3/2011

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F 431	Continued From page 22 stock. 3. Triamcinolone 0.1% cetaphil cream expired 5/22/11. 4. Novolog 100 u (units)/ml (milliliter) opened 6/29/11 expired in 28 days on label. Had been opened 31 days. 5. Three bottles of Natural Balance eye drops with no open date. 6. Dorzolamide Hcl 2% eye drops with no open date. 7. Amoxicillin 500 mg., 4 capsules packaged 4/29/11 with expiration date of 6/13/11. E11 (staff nurse) confirmed this medication was no longer in use.	F 431	will be taken to the monthly QI meeting by the RN supervisor. 4. Findings will be reported at the quarterly meeting by the RN supervisor.	9/3/2011
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F441 1. Infection Control RN was interviewed and made aware of	7/26/2011

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F 441	Continued From page 23 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by : Based on clinical record review, observation, interview, and review of the facility's policy and procedure it was determined that the facility failed to follow their infection control policy for one (R35) out of 25 sampled residents who had a diagnosis of MRSA (Methicillin-Resistant Staphylococcus Aureus-organisms that are resistant to the antibacterial action of methicillin... these pathogens are resistant to all pencillins and cephalosporins. Taber's Cyclopedic Medical Dictionary Ed. 19) of her eyes. Findings include: The facility's policy and procedure for "Residents with documented infectious processes requiring additional precautions" stated that Contact Precautions will be instituted for any resident who requires more extensive infection control measures. It also stated under procedure: 4. A sign such as "STOP AND SEE THE NURSE" will alert visitors to see the nurse prior to entering a	F 441	the deficient practice of not having a "STOP AND SEE THE NURSE" sign on the resident's door. Immediately after the problem identified, a sign was placed on the door. 2. All nurses will have Mandatory Education on the facility Infection Control Policies and Procedures and staff will demonstrate a working knowledge and understanding of subject by taking a post in-service test. 3. Any new cases requiring isolation will be audited by Infection Control RN on admission to ensure compliance with our policy and procedures. All staff, including Certified Nursing Assistants will complete a Silver Chair education on Resident Rights and Infection Control. Monthly audit of current residents on isolation will be completed by Infection Control RN to ensure ongoing compliance. 4. Findings will be reported monthly at QI meetings followed by Quarterly meetings for one year.	8/26/2011 9/3/2011 9/3/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085009	A. BUILDING _____ B. WING _____	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST MANOR HOUSE	1001 MIDDLEFORD ROAD SEAFORD, DE 19973

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 24 resident's room. R35 was a resident of the facility with diagnoses that included MRSA of both eyes. Review of the physician orders revealed on 5/24/11 the physician wrote an order for "Contact Isolation" for R35. Review of the July 2011 physician order sheet for R35 revealed a physician order that stated "...bilateral eye infection contact precautions only." On 7/25/11 at approximately 9:30 AM during the initial tour of the building R35's room was observed. There were no sign on R35's door alerting visitors to "Stop and see the nurse" prior to entering the room. On 7/29/11 at approximately 10:25 AM interview with E3 (RN/Infection Control) confirmed the facility failed to put a sign outside R35's room alerting visitors to see the nurse before entering the room as stated in their policy and procedures.	F 441		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085009	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/1/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST MANOR HOUSE	**1001 MIDDLEFORD ROAD SEAFORD, DE**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined that, for one(R63) out of 25 sampled residents, the facility failed to report an allegation of mistreatment to the State Agency, Division of Long Term Care Residents Protection. Findings include:

An incident that occurred on 10/30/10, involving R63 who alleged that two certified nursing assistants put him to bed contrary to the resident's wishes, was thoroughly investigated and brought to an appropriate conclusion by facility management but was never reported to the State Agency Interview with E1 (Administrator) and E2 (Interim Director of Nursing) on 8/01/11 at 10 AM indicated that the incident had been investigated, appropriate actions implemented, and the resident protected but was never reported to the State Agency because E14 (previous Interim Director of Nursing) failed to send the paperwork to the State Agency. Interview with R63 on 8/01/11 indicated that there was no problem with the incident as far as the resident was concerned.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Methodist Manor House

DATE SURVEY COMPLETED: August 1, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at the facility from July 25, 2011 through August 1, 2011. The deficiencies contained in this survey are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The census on the first day of the survey was fifty (50) and Stage II sample included twenty-five (25) residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross refer to the CMS 2567-L survey report date completed 8/1/11, F225, F241, F279, F282, F314, F318, F325, F371, F431, F441.	F225/483.13 1. Previous Interim Director of Nursing was responsible for not reporting incident to other officials in accordance with State Law. Plan in place to ensure that deficient practice will not recur. 8/9/2011 2. Charge Nurse will be notified immediately of every allegation of abuse. Charge Nurse will notify nursing administration. The charge nurse/RN supervisor will ensure that it is faxed to the Division of Long Term Care 8/9/2011

Provider's Signature Eileen K Hankinson RN NHA Title Executive Dir. Date 8/24/2011

NAME OF FACILITY: Methodist Manor House

DATE SURVEY COMPLETED: August 1, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	F225 **483.13(c)(l)(ii-iii),(c)(2)-(4) Investigation/report Allegations/individuals** **The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.** **The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).** **The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.** **The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and**	Resident Protection immediately. ADON/DON will investigate all allegations and complete a 5-day follow up report. All completed reports will stay in ADON/DON office. 3. Audit of all allegations of abuse will be done monthly by ADON/DON to ensure completion of reports. 8/26/2011 4. Findings will be reported monthly at QI meetings followed by Quarterly meetings for one year. 9/3/2011

NAME OF FACILITY: Methodist Manor House

DATE SURVEY COMPLETED: August 1, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that, for one (R63) out of 25 sampled residents, the facility failed to report an allegation of mistreatment to the State Agency, Division of Long Term Care Residents Protection. Findings include: An incident that occurred on 10/30/10, involving R63 who alleged that two certified nursing assistants put him to bed contrary to the resident's wishes, was thoroughly investigated and brought to an appropriate conclusion by facility management but was never reported to the State Agency. Interview with E1 (Administrator) and E2 (Interim Director of Nursing) on 8/01/11 at 10 AM indicated that the incident had been investigated, appropriate actions implemented, and the resident protected but was never reported to the State Agency because E14 (previous Interim Director of Nursing) failed to send the paperwork to the State Agency. Interview with R63 on 8/01/11 indicated that there was no problem with the incident as far as the resident was concerned.	